Public Health Watch

A BI-MONTHLY PUBLIC HEALTH NEWSLETTER OF THE
METROPOLITAN HEALTH DEPARTMENT OF NASHVILLE AND DAVIDSON COUNTY, TENNESSEE

Volume 5, Number 4 ISSN - 1009 - 7423 **July/August 2001**

Mobilizing for **A**ction through **P**lanning and **P**artnerships: A Community Roadmap to Health

Editor's Note:

On May 22, 2001, a reception was held at the Lentz Health Center to announce Nashville's selection as a demonstration site for the MAPP process. Mobilizing for Action through Planning and Partnerships (MAPP) is a community-wide strategic planning tool for improving community health. MAPP was developed as a joint collaboration of NACCHO (National Association of County and City Health Officials) and the CDC (Centers for Disease Control and Prevention). Facilitated by public health leadership, this tool helps communities prioritize public health issues and identify resources for addressing them. This issue of *Public Health Watch* describes the MAPP process, outlines the preparations made by the Metropolitan Health Department of Nashville and Davidson County to implement MAPP, and invites participation of public, private, and voluntary organizations, as well as community members and informal associations, in the process. *(More about MAPP on pages 4 - 15.)*

Foodborne Illness in Tennessee

Timothy F. Jones, M.D.
Epidemiologist, FoodNet Director
Tennessee Department of Health

Americans experienced an average of 1.4 diarrheal episodes per person per year in 1997.[1] Foodborne diseases cause approximately 76 million illnesses in the United States each year, accounting for 325,000 hospitalizations and 5,000 deaths.[2] Foodborne illness has been estimated to cost as much as $23 billion annually in this country.[3] Given the high incidence, foodborne diseases are likely to be encountered commonly by physicians, and responding appropriately can help limit associated morbidity.

There are a variety of reasons that rates of foodborne disease in the U.S. remain high.[4] The median age of the U.S. population is steadily increasing, and foodborne illness affects the elderly and very young particularly severely. Many Americans have increased their consumption of fresh fruits and vegetables in response to nutrition campaigns. We are accustomed to year-round access to a wide variety of fresh produce. Improvements in transportation and trade make it possible for food to be on our tables a day after it is picked from a field in a developing country. Rapid movement of both people and foods brings with it risks of importation of disease. International travel has increased dramatically, and last year there were 700 million international arrivals worldwide.

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Many other factors related to the handling of our food supply prior to consumption contribute to foodborne illness. For example, in one study 63% of observations in full-service restaurants were out of compliance with proper food holding time and temperature regulations. Of observed food workers, 53% were out of compliance with personal hygiene requirements.[5] Unfortunately, behaviors in the home are not necessarily any safer. In a population-based survey, 50% of persons reported eating undercooked eggs, 20% ate pink hamburgers, and a similar percentage did not wash hands or cutting boards after handling raw meats.[6]

The most common known causes of foodborne illness in the United States are listed in Table 1. Many people are surprised to learn that Norwalk-like virus is the most commonly identified cause of foodborne illness in the U.S. Disturbingly, however, 82% of foodborne illness is caused by unknown pathogens.[2] This high rate of "unexplained" illness can be attributed to a variety of factors, including delayed reporting and inadequate investigation, failure to collect appropriate specimens for laboratory testing, illness due to viruses or other organisms which are difficult to identify, and as-yet-unidentified pathogens.

Table 1. Most Common Known* Causes of Foodborne Illness in the United States^

Disease Agent	% of total estimated foodborne illness
Norwalk-like viruses	66.6
Campylobacter	14.2
Salmonella	9.7
Clostridium perfingens	1.8
Giardia lamblia	1.4
Staphylococcus food poisoning	1.3
Toxoplasma gondii	0.8
Yersinia enterocolitica	0.6
Shigella	0.6

*82% of foodborne illness in the U.S. is caused by unknown pathogens.

^ Adapted from Mead, EID 1999

Surveillance for Foodborne Illness in Tennessee

In Tennessee, as in other states, the most common causes of foodborne illness are required to be reported to the Department of Health, which monitors surveillance data and investigates cases as appropriate. Routine surveillance in Tennessee in 2000 identified approximately 346 cases of *Shigella*, 711 cases of *Salmonella,* 283 cases of *Campylobacter*, and 60 cases of *E. coli* O157:H7.

In 1999, Tennessee began participating in the Centers for Disease Control and Prevention (CDC) Foodborne Diseases Active Surveillance Network (FoodNet). In Tennessee, FoodNet surveillance is performed in Davidson, Cheatham, Dickson, Hamilton, Knox, Robertson, Rutherford, Shelby, Sumner, Williamson, and Wilson counties. This program provides for intensive, active surveillance for foodborne illness and participation in a variety of special studies. These include telephone surveys to assess the incidence of foodborne illness in the general population, physician surveys to determine clinician attitudes toward evaluating and preventing foodborne disease, and laboratory surveys to determine specimen handling practices (Figure 1).

The growth of the FoodNet program in Tennessee has substantially improved the ability of the public health infrastructure to respond to foodborne illness in the state. During outbreaks, the Tennessee Department of Health laboratory can now perform or arrange for polymerase chain reaction (PCR) testing for Norwalk-like virus, serology and augmented culturing techniques for *E. coli* O157:H7, stool testing for shiga-like enterotoxins, and pulsed field gel electrophoresis (PFGE) "fingerprinting" to determine the relatedness of bacterial isolates. PFGE testing is provided as part of PulseNet, a FoodNet program to allow rapid interstate comparison of bacterial DNA fingerprints, improving recognition and response to multi-state outbreaks.

The number of foodborne outbreaks in Tennessee reported to the CDC in recent years is shown in Figure 2. The incidence of foodborne disease in Tennessee during this period has probably been fairly stable. The dramatic increase in the number of outbreaks investigated and reported likely reflects improved surveillance and aggressive epidemiologic, environmental, and laboratory investigations of suspected outbreaks.

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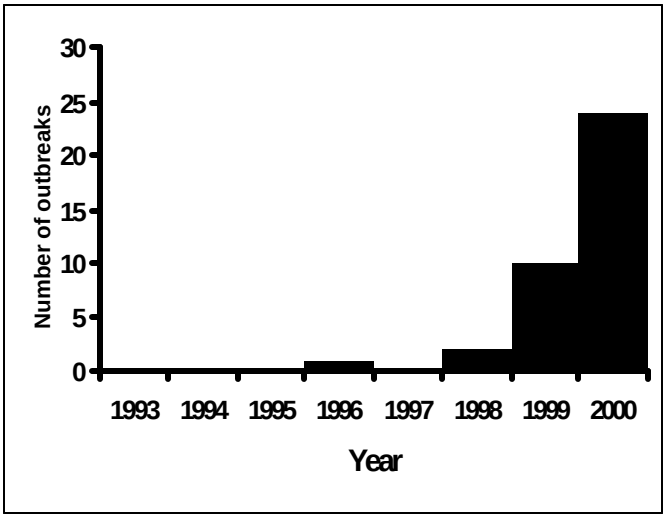
Figure 2. Number of Foodborne Outbreaks in Tennessee Reported to the CDC



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The Role of Clinicians

Community clinicians obviously play an important role in treating affected individuals and often are the first to recognize and report potential outbreaks. In the managed-care era, the usefulness of sending stool specimens for culture to evaluate acute gastroenteritis has been questioned. While culture may not be indicated in all isolated cases, the identification of a specific pathogen can be important to the appropriate management of many infections. For example, antibiotics are useful for some infections (such as those due to *Shigella*), are of no use in others (such as Norwalk virus or Staphylococcal enterotoxin), and can be potentially harmful in others (such as infection with *E. coli* O157:H7 or uncomplicated *Salmonella* infections).[1]

It is often difficult to differentiate these infections on clinical grounds alone. In addition, in the case of suspected outbreaks isolation of a pathogen can be extremely important to the public health investigation. Resources to help provide guidelines to clinicians in evaluating infectious diarrhea have recently been published.[1,7]

Potential foodborne-illness outbreaks should be reported immediately to the local health department. The Department of Health can assist in the evaluation of suspected outbreaks, arrange for outbreak-associated laboratory testing, and coordinate appropriate environmental inspections.

Information on foodborne and other reportable diseases is available by calling the Metro Health Department at (615) 340-5632.

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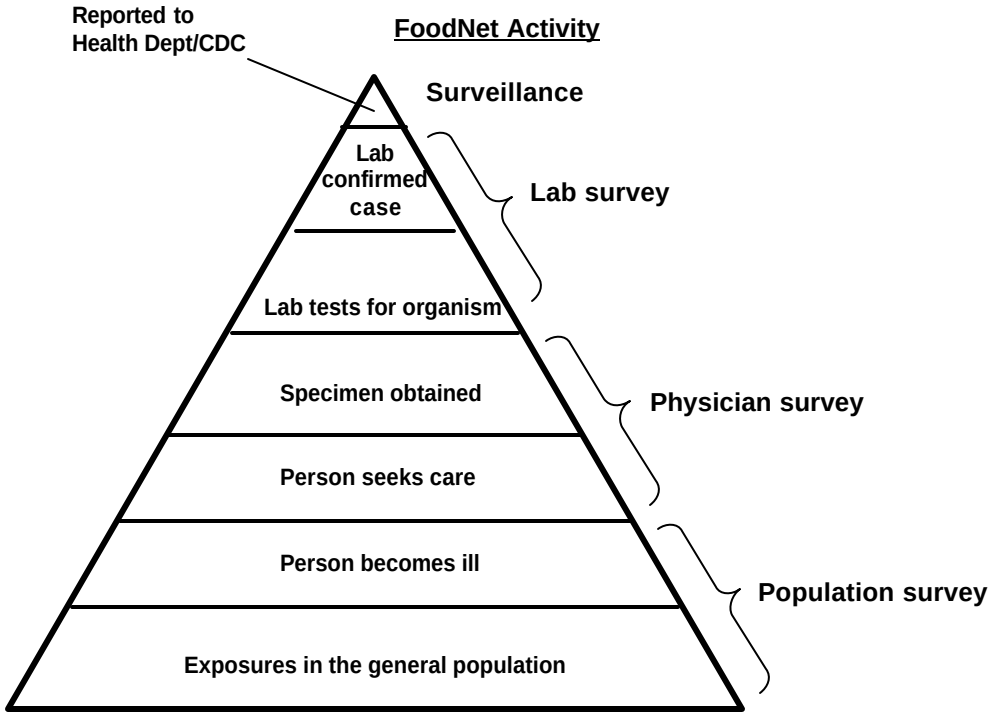
Figure 1. Burden of illness pyramid.* Only a small proportion of foodborne illnesses are laboratory confirmed and reported to the health department. FoodNet involves several studies aimed at determining the factors which affect the many other steps which must occur before illnesses are reported.



*Adapted from CDC materials

How MAPP Works

Two graphics illustrate the MAPP process. The Community Roadmap shown on page one presents the process as it moves along a road that leads to a healthier community. In the MAPP model shown on this page, the phases of the MAPP process are shown in the center of the model, while the four MAPP Assessments, the key content areas that drive the process, are shown in the four outer arrows.

To initiate the MAPP process, lead organizations in the community begin by organizing themselves and preparing to implement MAPP (**Organize for Success/Partnership Development**). The second phase of the MAPP process is **Visioning**. A shared vision and common values provide a framework for pursuing long-range community goals. During this phase, the community answers questions such as *"What would we like our community to look like in 10 years?".*

Next, the four MAPP Assessments are conducted, providing insights into challenges and opportunities throughout the community. The **Community Themes and Strengths Assessment** provides an understanding of the issues residents feel are important by answering the questions *"What is important to our community?" , "How is quality of life perceived in our community?",* and *"What assets do we have that can be used to improve community health?".*

The **Local Public Health System Assessment** is a comprehensive assessment of all of the organizations and entities that contribute to the public's health. This assessment answers the questions *"What are the activities, competencies, and capacities of our local public health system?"* and *"How are the Essential Services being provided to our community?".*

The **Community Health Status Assessment** identifies priority issues related to community health and quality of life. Questions answered during this phase include *"How healthy are our residents?"* and *"What does the health status of our community look like?".*

The **Forces of Change Assessment** focuses on the identification of forces such as legislation, technology, and other issues that affect the context in which the community and its public health system operate. This assessment answers the questions *"What is occurring or might occur that affects the health of our community or the local public health system?"* and *"What specific threats or opportunities are generated by these occurrences?".*

Once a list of challenges and opportunities has been generated from each of the four assessments, the next step is to **Identify Strategic Issues**. During this phase, participants identify linkages between the MAPP assessments to determine the most critical issues that must be addressed for the community to achieve its vision. After issues have been identified, participants **Formulate Goals and Strategies** for addressing each issue.

The final phase of MAPP is the **Action Cycle**. During this phase, participants plan, implement, and evaluate. These activities build upon one another in a continuous and interactive manner and ensure continued success.

The Action Cycle

The Action Cycle links three key activities—planning, implementation, and evaluation. Each of these activities builds upon the others in a continuous and interactive manner. During this phase, the efforts of the previous phases begin to produce results, as the local public health system develops and implements an action plan for addressing the strategic issues.

The Action Cycle can be summarized as follows:

- Planning: Determining what will be done, who will do it, and how it will be done.
- Implementation: Carrying out the activities identified in the planning stage.
- Evaluation: Determining what has been accomplished.

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Planning for Action:

- The participants begin to organize for action.
- Participants develop measurable outcome objectives for each strategy and determine who is responsible for attaining each objective.
- Participants develop specific action plans for each outcome objective that identify specific activities, timeframes, and needed resources.

Implementation:

- All individual and collective action plans are reviewed to identify common or duplicative activities and to seek ways to combine or coordinate the use of community resources.
- The action plans are implemented and monitored.

Evaluation:

- The entire MAPP process and each strategy are evaluated.
- An evaluation process is designed, i.e., questions the evaluation should answer, methodology for collecting data to answer the questions, plan for carrying out the evaluation activities, and a strategy for reporting the results.
- Data is collected.
- Results of the evaluation are shared and participants celebrate successes. The evaluation may also identify ways to improve existing processes and help create new strategies and activities.

As the community recognizes the hard work and celebrates the success of the MAPP process, the momentum is established to sustain the process and continue implementation over time.

Information taken from "A Strategic Approach to Community Health Improvement/MAPP Field Guide" provided courtesy of NACCHO and CDC.

MAPP
MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP)

Scenes from the MAPP Launch Event on May 22, 2001

Brian Todd, Public Information Officer for Metropolitan Health Department, talks with a guest at the MAPP launch event.

Nashville Launches MAPP: Mobilizing for Action through Planning and Partnerships

Alisa Haushalter, MSN, RN, CS

On May 22, 2001 the Metropolitan Nashville Davidson County Health Department proudly launched Mobilizing for Action through Planning and Partnerships (MAPP).

Thomas Jefferson is quoted as saying that *"The success of a nation should be judged by the health of its people not the wealth of its people."* Likewise, the success of a community should not be measured merely by its economic prosperity. A successful community is one in which everyone regardless of race, ethnicity, gender, age, or socioeconomic status has equal opportunity to achieve optimum health.

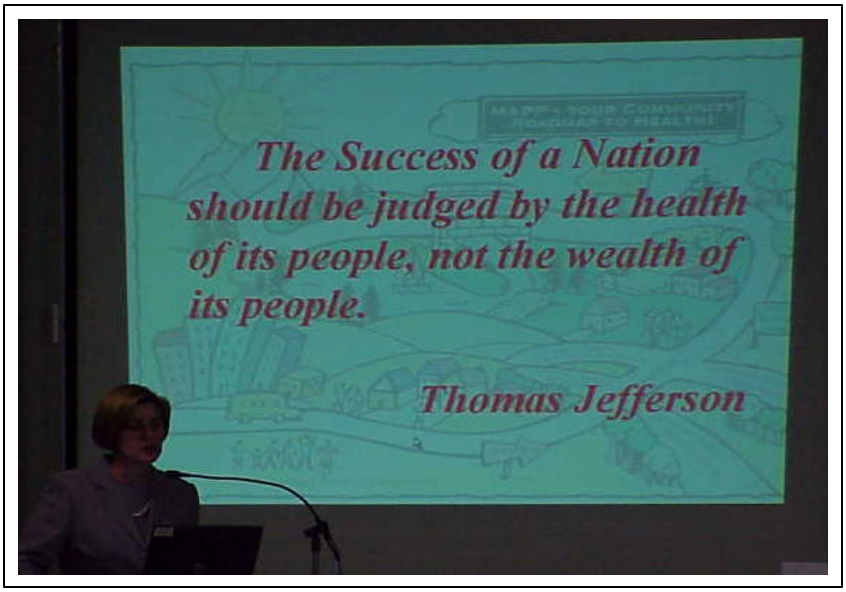
A successful, healthy Nashville is on the horizon, visible to many but still miles away. A healthy Nashville is achievable through the efforts of the many who dedicate their lives to making a difference through the work they do and the partnerships they forge.

Nashville presently has many oars in the water propelling our city to become healthier, healthier for all. Our city has a new mayor who supports neighborhoods as well as a fit workforce. Our city has a strong health department with visionary leadership. Our city also has a Board of Health committed to being active advocates for health improvement. Most importantly our city has many strong partnerships, all striving to make Nashville a city where everyone has an equal opportunity to be healthy. Partnerships include five Healthy Nashville community coalitions, the Meharry-Vanderbilt Alliance, Racial and Ethnic Approaches to Community Health (REACH), and the Consortium of Safety Net Providers (CAP) as well as many others. These and other partnerships have made the vision of a healthy city more than a mere dream. They have opened the door for dialogue and action that will move our city towards great success.

Alisa Haushalter addresses guests at the MAPP launch on May 22, 2001.

The National Association of County and City Health Officials and the Centers for Disease Control and Prevention designed MAPP, a strategic planning tool for community health improvement. Nashville was selected as one of nine demonstration sites nationwide after participating as one of forty review sites. By serving as a demonstration site, Nashville will be looked to as a model city for the implementation of MAPP.

MAPP was launched to support and compliment existing efforts. Collectively, we can create a city that is judged successful in the eyes of a leader the likes of Thomas Jefferson.



Alisa Haushalter describes Thomas Jefferson's measurement of a successful community as she describes how MAPP will contribute to this status in Nashville.

Message from Mayor Bill Purcell

Kelvin Jones, Special Assistant for Legal Affairs, Mayor's office

Nashville is honored to have been selected as a demonstration site for MAPP. Nashville is the health care capitol of the United States.

In regards to health care, the goals of Mayor Purcell's administration are to eliminate the disparities that exist in our community and to recognize health care as a priority in our community. Whereas education, employment, and crime prevention all deserve "top billing" so should health care because in many ways it is the foundation of everything that we do.

- A healthy child can be educated.
- Good health is essential to the reduction of crime and recidivism.
- A healthy employee is a productive employee.

For these reasons, health deserves the attention of our community.

We feel that because of the relationships that have been developed in the Nashville community the synergy is present to make Nashville a successful MAPP demonstration site.

Janie Parmley, Chairman, expressed the support of the Board of Health for Nashville's selection as one of nine demonstration sites nationwide for MAPP.

Janie Parmley, Chairman of the Board of Health, and Kelvin Jones, Special Assistant to Mayor Purcell for Legal Affairs, talk with guests prior to the MAPP launch.

Metropolitan Health Department's Youth Advisory Board Supports MAPP

Karen Baer and Gabrielle Schonder

Karen Baer

I want to live in a city that is continually improving the health of the environment and the people who live in it.

I want to live in a city where statistics for cancers, sexually transmitted diseases, obesity, eating disorders, and other diseases are going down, reflecting the good of the city and not the bad.

I want to live in a city that takes care of its environment by reducing, reusing, and recycling.

I want to live in a city where pollution in the air and water is less than it has ever been.

I want to live in a city where trash is minimal and manageable.

I want to live in a city where the people and the environment are always getting brighter, healthier—better.

Gabrielle Schonder

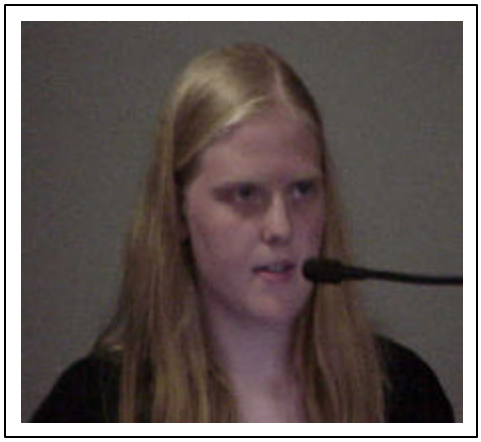
I want to live in a city that consists of people that are happy with their lives and people who are working to make changes for the better.

I want to live in a city where more community oriented events happen.

I want to live in a city where physical and emotional health is a priority.

I want to live in a city where my best friend can have access to Planned Parenthood and suicide hotlines.

I think that Nashville is a city that I want to live in, a city that celebrates its success and progress.



Allison Wiley

Allison Wiley

I am ready to create my city:

Where pollution is a third grade vocabulary word and not a problem.

Emma Cermak

Emma Cermak

I am ready to create my city:

- *Where I don't have to worry about where I go at night,*
- *Where a group of neighbors create a community, not just a housing complex,*
- *Where the amount of respect that I receive from others is based on the amount of respect I give, not based on my age, gender, or race.*

I am ready to stop talking about what I would make my city if I had the chance. The chance is here and it is time to act.

Editor's Note:

On May 21st and 22nd, 2001, a team of four NACCHO (National Association of County and City Health Officials) members visited Nashville as part of the official announcement of Nashville's selection as a MAPP demonstration site. The team visiting Nashville included:

- *Patrick Lenihan, Ph.D., Deputy Commissioner, Department of Public Health, Chicago, Illinois; Vice-President NACCHO*
- *Erica Salem, M.P.H., Director of Planning and Development, Department of Public Health, Chicago, Illinois*
- *Vaughn Upshaw, DrPH, EdD, Clinical Assistant Professor, Department of Health Policy and Administration, University of North Carolina at Chapel Hill*
- *Scott Fisher, M.P.H., Program Associate, Research and Development, NACCHO*

On the 22nd, the team agreed to discuss the MAPP process, Nashville's selection as a demonstration site, and their thoughts on how Nashville would be impacted by the MAPP process. Following is a transcript of this discussion.

The NACCHO team who conducted the site visit May 21 - 22, 2001, from left to right: Patrick Lenihan, Erica Salem, Vaughn Upshaw, and Scott Fisher.

Question 1: What were the origins of MAPP?

Patrick: MAPP is the latest public health planning tool that has been developed by NACCHO, the Centers for Disease Control and Prevention (CDC), and the public health community. It recognizes that with all the changes that have gone on with public health, more than APE*XPH* (Assessment Protocol for Excellence in Public Health) [1] is needed to be able to get public health agencies to be more relevant to their communities, to be able to engage their communities, and to be able to garner resources that they were not able to garner using APE*XPH* alone. APE*XPH* was good at looking inside the health department to see what the capacities were, and to understand from those capacities what changes needed to be made to make the health department minimally effective in being able to address health status issues. Those health status issues were determined through the second part of APE*XPH* which looked outside of the health department and determined what variety of needs were out there; and hopefully by pulling the two together the health departments would have the capacity to meet the community needs. But, there is a whole lot out there beyond just the health department in terms of resources and in terms of other players. There needed to be a way that health departments could engage these other players, to engage their communities, and do more than just select a limited number of health status issues and then apply their resources and their capacities to these issues. That is the thinking behind MAPP.

[1] APE*XPH* was funded by a cooperative agreement from CDC to NACCHO. It began in July 1987. After four years of collaborative development and testing by various national public health organizations, the APE*XPH* Workbook was released in March 1991. APE*XPH* was developed to be used voluntarily by local health officials to assess the organization and management of the health department, provide a framework for working with community members and other organizations in assessing the health status of the community, and establish the leadership role of the health department in the community.

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MAPP features three things to address those problems. One, it recognizes that while you can analyze a lot, you cannot do everything at once, and you have to be strategic. So MAPP takes a strategic approach to looking at community problems and engaging community players to address those problems. Everything cannot be important at the same time. It is important to determine what are the most important things. Secondly, it recognized that even a well-equipped and well-funded health department, if there is such a thing in the United States, is never going to have the resources to do all the things it needs to be doing. So it has to be able to draw resources or leverage resources from outside its walls in the community, particularly from those institutions and health care providers that often have much larger budgets than health departments do. While health departments have been involved in delivering health care services, they still play a very minor role and so must be able to tap into those larger resources. Garnering that resource base is one of the intentions of MAPP. And finally, there is community engagement. It is not enough to bring communities around the table to determine what the problems are, what the health status issues are. We have done that for years. Communities have to be engaged at the systems level if their resources are going to be drawn on to be able to deal with this broader range of problems that public health agencies are now attempting to tackle. So it is the systems approach, the use of strategic planning or strategic thinking, and a process of community engagement as related to the systems approach, the systems knowledge. It is not just the health department. It is that network of community agencies, both grass roots and institutions, that collectively can deal with a full range of problems which health departments are going to need to address if they are to be more effective in improving the health of the communities and not just with dealing with limited health status issues.

Question 2: What are the other MAPP sites?

Amherst, MA
Hartford, CT
Columbus, OH
Lee County, FL
Mendocino County, CA
Northern Kentucky District, KY
San Antonio, TX
Taney County, MO

What criteria were used to select the demonstration sites?

Scott: We first looked at who participated in the review of the paper draft of the tool, when it was formally known as APEX*CPH* (Assessment and Planning Excellence through Community Partners for Health). That was the number one criteria. You had to have been a level one review site in order to be selected as a demonstration site. From there we looked at geographic location, the size of the community the health department served, the type of structure within the health department, and also enthusiasm for wanting to be a demonstration site. These were the basic criteria that we used to determine the sites.

Question 3: How will the Nashville community benefit from the MAPP process?

Erica: Going back to what Patrick said about the strategic thinking, I think the community, by going through the MAPP process, should come out with a greater capacity, a sustainable capacity, for strategic thinking, so that you do not just pick apart a single health status issue but that you have a foundation for strategic decision making. We did a process in Chicago that was similar to MAPP, and what separates it for me is the strategic planning and moving the strategic planning from outside of just an organization. You have experienced this community based strategic planning.

Question 4: Has the process been used previously?

Erica: We did not formally use MAPP in Chicago but under our Turning Point Initiative we used a process that mirrors MAPP in many ways. It has all of the same basic steps. We carried out the assessments a little differently because the MAPP tool was not completed, and we were doing two things at once. Turning Point is a Kellogg and Robert Wood Johnson Foundations (RWJ) initiative to engage in planning to strengthen local public health systems and to prepare them for future challenges.

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Patrick: There are two examples of how a process like this can be used to pull together or coordinate other resources so that the responsibility for public health is shared in the community. The first one that I would point to is the role of the business community. I know that health departments, particularly in larger cities, see the business community as a potentially very important ally because they are very often influential people, who have political connections, and they certainly control resources. If you can get business leaders to be supporters of public health, to understand the value of public health in their community, this would be an important asset in making public health more important to the broader community. So we set that out as a goal for our Turning Point Initiative.

One of the things we wanted to do was to make the business community aware of the role of public health and then make business a champion of public health in the arenas in which they are influential. So we invited representatives of the business community at the highest level into the Turning Point Chicago Partnership for Public Health. The Civic Federation is approximately 100 of the largest businesses in the Chicago area, primarily in the city of Chicago, whose leaders or whose boards take an interest in civic affairs. We invited the Civic Federation to appoint someone to the Turning Point Partnership. They appointed their policy person, and he has been participating now for over two years. He attends every meeting and has even been going to some of the national forums that Kellogg and RWJ have sponsored and it has been very useful. We thought, naïve people that we were, once we got them around the table we would educate them about public health and show them what a great job we were doing so that they would support us. Well, we recognize that the business community behaves much like the community at large in that there is a diversity of interests there, that they are a difficult group to persuade, and that there are not that many things that they mobilize behind. One value to us that we did not see was gaining an understanding of the business community that we did not have before, that allowed us to see what we need to do in public health in order to get the business community to understand and to be supportive. Some things they can understand easily. Some things you are never going to sell them. One thing that they share in common with the community at large is that you can not just give them information and have them say, "Oh yes, now we see the light." They are a lot more easily persuaded by numbers than the community at large because they deal with numbers on a daily basis. But they are more interested in financial numbers. They want to know the cost/benefit of things. They want to understand what the effect is on tax dollars. They want to understand what kinds of economic gains are going to occur from public health. So it causes us to think of public health in a new way. We also learned that they are not quick to engage in political sponsorship. They will not throw their weight behind advocacy efforts. And so, I think that it is naïve for public health people, at least in Chicago, to expect to quickly persuade the business community to support advocacy, say for tobacco. But on the other hand, they might be persuaded, if we can craft an argument and engage them long enough, to expand the Kid Care Program or to address some of the issues that we have been attempting to address in the Kid Care Program to reduce some of the barriers and make it more efficient. We need to talk not in terms of access but in terms of efficiency, a bad use of taxpayer dollars. Engaging the business community and learning about them and having them learn about us will set the stage for an ongoing dialogue. They have been supportive of the health department, particularly during our budget hearings. And to have the business community, the civic community, speak highly of the work being done by public health was a major plus.

Erica: The Civic Federation testifies before the City Council every year about the city budget. They are a government watchdog group, and part of their goal is to make sure that the public

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Guests fill the Lentz Health Center Auditorium to learn about MAPP.

David Campbell, Regional Prevention Coordinator, talks with Atha Jackson, Health Educator for the Screening Team, Nashville REACH 2010.

dollar is spent wisely. In giving their annual testimony, they invoked the health department as an example of money wisely spent. I just want to say a little more because I think we learned also in terms of the business community about the need for public health compromise. If you want other people at your table, you know they are not going to come to the table and say, "Ok, whatever you say." The reality is that our partnership had a simple strategy, advocating for tobacco dollars to be used for public health. The Civic Federation has Philip Morris and R. J. Reynolds, the tobacco companies, on their board. And they would not have their name on the document, on our plan which was so much bigger than that one recommendation. That was not the vehicle for them to use to address this issue. It was very interesting watching because the reality is there is already so much going on with tobacco advocacy in Chicago and Illinois. So having this little sentence in the document was not going to make a difference in the outcome. It was only an ideological statement. So what you could see was some of the more traditional public health people just sitting firm and saying "We are not compromising." You have got to compromise if you want other people to come to the table, if you want their support, if you want their resources. Who is to say that our way is the only right way to do it. I have friends who have nothing to do with public health and their tax dollars go to a county health care system that pays for everybody with lung cancer. Well, maybe they do deserve a tax rebate. That is not how I want to see the money spent, but maybe there are other legitimate uses besides public health. I personally do not see them, but you have to try to see them. So I think that is one thing I learned about.

Patrick: It is really when we deal with the community that we talk about the need to listen, and I think that is also true at the policy level. We are too quick at the policy level to take these black and white positions, we are right, they are wrong, and expect others to side with us. While public health traditionally has talked about operating in a political environment, it has never been really effectively done. It is largely because public health workers tend to be zealots about their issues not recognizing that nothing gets done quickly in a political environment in this country. For public health people to be effective in the policy arena, they need to recognize that just because they change their strategy they are not compromising their beliefs or their values. Sometimes you have to take an incremental approach. Sometimes you have to back off because the timing is not right. Just raising your flag up there and shaking it vigorously may make you feel good but it is not going to help you in getting things done.

Another policy example, one of the first things that the Turning Point Partnership did was to develop a common policy agenda for this session of our state legislature. It involved 60 people, 60 organizations.

Erica: It came out of our assessment activities which showed that a lot of organizations in Chicago report that they are doing public health policy work, but that we are all doing it a little differently so that we are not sounding like we are speaking with one public health voice. So we are relatively ineffective.

Patrick: By doing that we were able to come together with an agenda which took us longer than we thought, because getting through this was a long process, and we probably missed the opportunity this year to be influential in this session of the General Assembly. But we have set the stage in that these people now have this agenda, they are used to working with each other, and it becomes a menu for next year. As opportunities arise we can pull things off that menu and concentrate our efforts in a half dozen policy areas which we have identified through key pieces of legislation. And hopefully we increase the opportunity of getting something done. Rather than have everyone work on 24 things individually, maybe we jointly do 3 things, but do them in a way in which you are not stepping on each other in an uncoordinated, and in some cases competitive way, and canceling each other out. So I think the MAPP approach is valuable for coordinating action particularly where you have a large city like Nashville where there is a lot going on. It is as important to concentrate and coordinate the action as it is to determine what it is you need in the first place.

One more point on MAPP is that it is really important for cities like Nashville. One of the values of having Nashville as a demonstration project is size and the richness in capacity of this health department. I think if any larger areas can do this, Nashville should be able to because you have all the ingredients in place. Now as kind of an introduction, let me say, the Nashville approach is not a cookbook. MAPP at this point is more of a toolbox. We are going to learn, we the public health community, about how MAPP should be applied based on what Nashville does, about what Columbus and the other eight demonstration sites do. I think you are going to find all these different flavors of MAPP so that health departments who want to do it won't have to wrestle with a huge website and all these

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tools and say, "Oh, my goodness, what do I do?". They will look at what Nashville does and what Columbus does and what some of the other sites do, and they can see in a very practical and applied way how MAPP can be used to solve problems that they are facing and be able to fit MAPP to the situation and resources that they have. So how Nashville does MAPP is going to be unique and it is intended to be that way. There is no right way or wrong way to do that.

Question 5: What are your impressions of Nashville's preparations as a MAPP site?

Vaughn: Patrick has already alluded to some of the things that you have as resources here. I think that the things that have impressed me over the past couple of days are: your organization; the health department's commitment to population based health improvement; the depth of your epidemiology and research agenda already in place; and the efforts that are made to bring the program areas together routinely to look at how you are using your resources. You are asking, "Are we really getting at the roots of problems rather than treating symptoms?". So you already have an internal philosophy that fits very well with what MAPP is about.

Then building upon that, you have a network of coalitions and organizations in partnerships with the health department that is already in place, so a lot of the work that MAPP talks about in organizing for success you already have as an infrastructure that you can draw upon. I think that other places have a lot of legwork that they need to do to get to the point that you are already in. Then, as an external perception, and I don't know how much of this is true but just from listening to some of the history here in the Nashville area, you have strong partnerships and ways in which the medical schools work with one another and with the community. Another example is the placement of the REACH program in a comprehensive health center, that's also partnered back over here.

Metropolitan Davidson County Councilman Phil Ponder attended the MAPP launch on May 22, 2001.

You already have in the broader community a commitment to working collaboratively around issues of public health. I think that all of these things combined make this setting uniquely well prepared for MAPP. It won't be something that will be antithetical to the way in which you already operate. Obviously, there are going to be challenges. The toolbox may include tools that are different from the ones you routinely use. It may require that you have to think a little differently about how those parts come together. But the priority setting easily translates here not only into a policy agenda but into a programmatic agenda where those partners coming together identify issues based on data, resources, and commitment. The forces of change, the external pressures, whether it be syphilis or stroke, cancer or heart disease, or whatever the thing is, the momentum exists to support it. The priority setting and being able to say from across the community that we, instead of using our own way to address this problem, we are going to look collectively at how we might come together to address this problem from our city or county perspective. I think MAPP offers a mechanism for that dialogue to occur. You have got the pieces in place for that to happen, it's just that MAPP is hopefully going to help you convene the conversation. It would also be a good vehicle for bringing together the number of coalitions that you either convene here already or are currently members of. That was really impressive to us, it was really astounding.

Erica: Doing MAPP is a way of bringing these efforts together along with other things, and perhaps not picking apart a specific health problem, but also identifying common systems related issues that are shared, and faced, when people are trying to address a community health issue, be it access, sexually transmitted disease, or teen pregnancy. Clearly, access is a cross-cutting systems issue that may help the community impact and address more than one health status issue at a time. I think that is definitely a possibility and something that I hope for in Chicago.

Patrick: That represents probably the most productive way that public health can take action at the community level. Dealing with health status issues one at a time is very inefficient because you end up shifting resources around year after year. Once you recognize that you have all these connections and go up a level and try to put into place a system that deals with them all concurrently. It is more sustainable.

Vaughn: I am thinking of one of the conversations we had yesterday with Bart

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Perkey about the information system collaborative coming up with a way for the uninsured to have a standard medical record. He did not say medical record, but an information system. I think that is a good example of an initiative already in place that is a system capacity, and MAPP may facilitate more of that kind of creative thinking.

Patrick: One point that I would make, and this came up at one of the meetings yesterday, is that people expect that some concrete action is going to come out of this: that they are immediately going to be able to solve a problem. I think that they are looking at it the way you would look at program planning as if you were planning to reduce infant mortality or if you were planning to increase the immunization rate. The action that you are going to get out of this is increased capacity. It is going to be setting the stage so you can do all these other things, and while that may not be as satisfying in the short run as seeing your infant mortality rate go down or seeing your immunization rate go up, unless you have that capacity you are not going to achieve those gains. So it is more akin to making an investment than it is spending on the end product. By making this investment now you will have the capacity to deal with all these other things. I think that is how communities need to look at the value of this. This is investing in community health improvement as opposed to just directly putting money at these little problems that keep coming up.

Vaughn: I think that another big challenge is that people are going to need to see this process as their process and not the health department's. In making this successful, certainly the health department has pivotal leadership roles but only 5% of the resources in capacity are going to be here at the health department. If MAPP is going to make a difference for Nashville, it is because Nashville wants it to not because the health department wants it to.

For additional information about MAPP, please contact Alisa Haushalter at 340-0407 or at alisa_haushalter@mhd.nashville.org. You may also obtain more information from NACCHO at the website www.naccho.org.

Foodborne Illness in Tennessee....continued from page three

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"Growing Up with HIV/AIDS: Issues in Prevention and Quality of Life" Conference to be held in Memphis on October 4 - 5, 2001

The "Growing Up with HIV/AIDS: Issues in Prevention and Quality of Life" Conference will be held in Memphis on October 4 - 5, 2001. The conference is focused on adolescents and children infected and affected by HIV/AIDS. It is sponsored by the University of Tennessee Health Science Center Boling Center for Developmental Disabilities, University of Tennessee College of Nursing, St. Jude Children's Research Hospital, Memphis HIV Family Care Network, and the Southeast Tennessee Development District. For more information about this conference, please contact Carol Greenwald at 901-448-2660, email cgreenwald@utmem.edu, or visit the website at www.utmem.edu/bcdd and follow the link.

Editor's Note:
There was no May/June 2001 issue of *Public Health Watch.*

Creating a Healthy Community through MAPP

Stephanie B.C. Bailey, M.D., M.S.H.S.A., Director of Health

As described by Dr. Jeffrey Koplan, Director of the Centers for Disease Control and Prevention, the public health community in the new millennium faces ten significant challenges. They are to: 1) institute a rational health care system, 2) eliminate health disparities, 3) focus on children's emotional and intellectual development, 4) achieve longer "healthspan", 5) integrate physical activity and healthy eating into daily lives, 6) clean up and protect the environment, 7) prepare to respond to emerging infectious diseases, 8) recognize and address the contributions of mental health to overall health and well-being, 9) reduce the toll of violence in society, and 10) use new scientific knowledge and technological advances wisely.

To address major public health concerns in the nation, ten leading health indicators were chosen based on their ability to motivate action, the availability of data to measure their progress, and their relevance as broad public health issues. These leading health indicators are: 1) physical activity, 2) overweight and obesity, 3) tobacco use, 4) substance abuse, 5) responsible sexual behavior, 6) mental health, 7) injury and violence, 8) environmental quality, 9) immunization, and 10) access to health care.

To create a healthy city, the entire community should be involved. Mobilizing for Action through Planning and Partnerships is our community's roadmap to health.

These indicators are the bases from which communities will be compared in a report card-like spotlight, because they mirror the objectives of Healthy People 2010. Each one impacts our neighborhoods and our community. To address these indicators and/or challenges calls for emphasis on health promotion, early intervention, involving neighborhoods, and partnering. Health promotion is the center of most of our efforts addressing the indicators.

A recent survey shows that many of our community leaders think that health promotion should be an emphasis of our department. Many community leaders also point out that the health department alone cannot realize health promotion. To create a healthy city, the entire community should be involved. Mobilizing for Action through Planning and Partnerships is our community's roadmap to health.

Currently, Metro Health Department has 466 dedicated public health professionals (60% white, 35% black, 4% Hispanic, and 3% other races) and a budget of 30 million dollars. Since 1994, the health department actively began engaging in community building processes the latest being the convening of the ten safety net providers and emergency room directors. Internally, we have restructured to do community surveillance and to assure systems are working for access to care and quality outcomes.

Our observances over the ensuing years have confirmed that there was not an effective system of health care delivery. Some things are not getting done, some assurances were not in place, and residents were not accessing services, particularly preventive/early diagnostic. There are surfacing problems around mental health, preventive dental care, acute dental care, EPSD&T (Early Periodic, Screening, Diagnosis, and Treatment), refugee services, Kids in Custody, and even some communicable diseases like syphilis have reappeared because an effective delivery system is not in place.

Given our observances, the challenges for public health, and the health status indicators, I think it is important to know what direction this community wants to move towards. MAPP will be an invaluable strategic tool to help us reach our goal of being a healthy community…and there's a part for you to play.

Reported cases of selected notifiable diseases for May/June 2001

Disease	Cases Reported in May/June		Cumulative Cases Reported through June	
	2000	2001	2000	2001
AIDS	69	33	210	115
Campylobacteriosis	10	7	21	16
Chlamydia	477	353	1,276	1,101
DRSP (Invasive drug-resistant *Streptococcus pneumoniae*	2	3	24	15
Escherichia coli 0157:H7	1	3	1	3
Giardiasis	2	1	14	5
Gonorrhea	442	299	1,179	856
Hepatitis A	6	5	34	15
Hepatitis B (acute)	8	0	26	5
Hepatitis B (perinatal)	0	0	15	11
HIV	74	43	260	170
Influenza-like Illness	0	0	705	131
Neisseria meningitidis disease	2	2	6	7
Salmonellosis	5	7	16	22
Shigellosis	3	0	10	3
Syphilis (primary and secondary)	33	14	97	41
Tuberculosis	18	8	46	27
VRE (Vancomycin-resistant enterococci)	8	1	26	31

To report a notifiable disease, please contact:

Sexually transmitted diseases: Pat Petty at 340-5647
Tuberculosis: Diane Schmitt at 340-5650
AIDS/HIV: Mary Angel-Beckner at 340-5330
Hepatitis C: Jennifer Blackmon at 340-5671
Hepatitis B: Cherese Brooks at 340-2168
Vaccine-preventable diseases: Denise Stratz at 340-2174
All other notifiable diseases: Pam Trotter at 340-5632

Public Health Watch welcomes feedback, articles, letters, and suggestions. To communicate with *Public Health Watch* staff, please:

Telephone: (615) 340 - 5683
Fax: (615) 340 - 2110
E-mail: nancy_horner@mhd.nashville.org

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